

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04813

Reg. Dist. No. 110

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>East New Market</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>East New Market</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Herman</u> (Middle) (Last) <u>Bailey</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 16 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 25 1886</u> 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>64</u> yrs. <u>0</u> Months <u>11</u> Days
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Jane Bailey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Flossie Bryan, East New Market, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)

Acute Bronchitis - Viral

INTERVAL BETWEEN ONSET AND DEATH

1 week

Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Chronic myocardial Degeneration1 weekII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5/14, 1951, to 5/16, 1951, that I last saw the deceasedalive on 5/14, 1951, and that death occurred at 7:15 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 19 1951</u>	<u>Washington Cent.</u>	<u>Hurlock Dist. Md</u>	
DATE REC'D BY LOCAL REG	REGISTERAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 19 - 1951</u>	<u>Chas. W. Hastings</u>	<u>Herbert M. St. Clair Jr.</u>	<u>Cambridge Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 31 1961
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11.6

04814

1. PLACE OF DEATH: COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Cambridge</u> TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.#1</u>		STREET ADDRESS <u>R.F.D.#1</u> (If rural, give location)	
3. NAME OF DECEASED (First) <u>JOHN</u> (Middle) <u>E.</u> (Last) <u>BURTON</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>(20)</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7/24/1891</u>
9. AGE last birthday <u>59</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Timberman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>General Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Madison, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William E. Burton</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Burton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs. John Burton-Cambridge RFD 1, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Myocardial Infarct

INTERVAL BETWEEN ONSET AND DEATH

5-10 min.

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Coronary Sclerosis2-3 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) _____	(COUNTY) _____	(STATE) _____
TIME (Month) (Day) (Year) (Hour) OF INJURY _____	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? _____		

22. I hereby certify that I attended the deceased from 4-28, 1941, to Aug 20, 1951, that I last saw the deceased alive on 5-16, 1951, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Eldridge H. Wolff, M.D.Cambridge, Md.5-21-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/22/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park- Cambridge, Maryland</u>	LOCATION (City, town, or county) (State) _____
DATE REC'D BY LOCAL REG. <u>May 23, 1951</u>	REGISTRAR'S SIGNATURE <u>John Mace, Jr., M.D.</u>	24. FUNERAL DIRECTOR <u>LeCompte Funeral Service,</u>	ADDRESS _____

Cambridge, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MAY 24 1951

04815

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERSReg. Dist. No. 112

1. PLACE OF DEATH- COUNTY <u>Dorchester</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ernest</u>	(Middle) <u>William</u>	(Last) <u>Carl</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 15, 1893</u>
9. AGE last birthday <u>57</u> yrs.		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>8</u> (Year) <u>1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Carl</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Carl</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT <u>Mary J. Carl, Vienna, Maryland</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>	<u>15 min</u>
Antecedent cause(s) (b) <u>4/20/1942</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	
(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 11, 1951</u>	<u>Vienna Cemetery</u>	<u>Vienna, Maryland</u>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 11 - 1951</u>	<u>Elizabeth H. Craft</u>	<u>K.J. Frampton and Son, Federalburg, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

510246

RECEIVED
MAY 15 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

04816

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11.6

1. PLACE OF DEATH - COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Dor</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> OR <u>few hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md Hosp.</u>		STREET ADDRESS (If rural, give location) <u>7 Charles St.</u>	
3. NAME OF DECEASED (First) <u>Baby</u> (Middle) <u>Boy</u> (Last) <u>Cropper</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 8 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nothing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>8</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mins.
11. BIRTHPLACE (State or foreign country) <u>Cambridge Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T Tyod</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louise Cropper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Alice Bowley, Cambridge Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Prematurity. 26 weeks gestation.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 8 1951</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 8, 1951, to May 8, 1951, that I last saw the deceased alive on May 8, 1951, and that death occurred at 1:50 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Lida C. BenedictPhysician Cambridge, MarylandMay 12, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 9 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>	LOCATION (City, town, or county) <u>Cambridge Md.</u>
DATE REC'D BY LOCAL REG. <u>May 17, 1951</u>	REGISTRAR'S SIGNATURE <u>John Mace, Jr.</u>	24. FUNERAL DIRECTOR <u>Herbert N. St. Clair, Jr.</u>	ADDRESS <u>Cambridge Md</u>

905081 99426V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 21 1954
BUREAU A.D.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04817

Reg. Dist. No. 110

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Maryland Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Josephine</u> (First) <u>Belt</u> (Middle) <u>Eggen</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1/24/68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles R. Belt</u>		14. MOTHER'S MAIDEN NAME <u>Antoinette Blake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. P. Richardson (Daughter)</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) <u>Coronary occlusion</u>			15 Min.
Antecedent cause(s) (b) <u>giving rise to the above cause stating the underlying cause last</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>John M. ...</u> (Degree or title) <u>M.D.</u>		ADDRESS <u>Cambridge, Md.</u>	
DATE SIGNED <u>5/29/51</u>		Deputy Medical Examiner	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/31/1951</u>	
NAME OF CEMETERY OR CREMATORY <u>London Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>5/31/1951</u> <u>Charles Hasting</u>		24. FUNERAL DIRECTOR <u>F.B. McLaughlin</u> ADDRESS <u>Hurlock, Md.</u>	

BUREAU V. S.

JUN 4 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04818

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> OR TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Simers Road</u> OR TOWN <u>md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hospital</u>		STREET ADDRESS (If rural, give location) <u>Church Creek R.F.D.</u>	
3. NAME OF DECEASED (Type or Print) <u>Seroma</u> (First) <u>-</u> (Middle) <u>Elliott, Jr</u> (Last)		4. DATE OF DEATH <u>May 12</u> (Month) <u>12</u> (Day) <u>1957</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>53</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Seroma Philips, S.R.</u>		14. MOTHER'S MAIDEN NAME <u>Ella May Philips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Seroma Philips, Simers Road</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Tetanus

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

18 hours

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 11, 1957, to May 12, 1957, that I last saw the deceasedalive on May 12, 1957, and that death occurred at 5:40 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

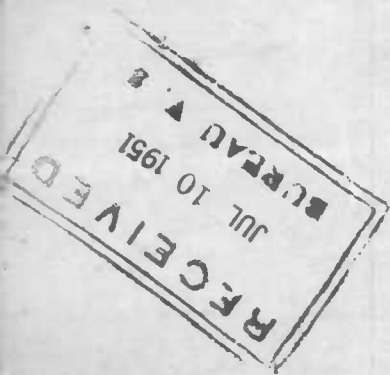
ADDRESS

405/21201 388

— MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-15



MARYLAND STATE DEPARTMENT OF HEALTH

04819

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Wor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>rural Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>JAMES</u> (Middle) (Last) <u>GILLIS</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>3/2/16</u>
9. AGE last birthday <u>35</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John H. Gillis</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Maddox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Eastern Shore State Hospital records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Encephalitis with lesion of the vital centers

24 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Status Epilepticus

36 hrs

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Psychosis with Epilepsy

several years.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)

SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 18, 1948, to May 15, 1951, that I last saw the deceasedalive on May 15, 1951, and that death occurred at 9 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

R. H. Blackboulder M.D., Eastern Shore State Hospital, Camb., Md. 5-15-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

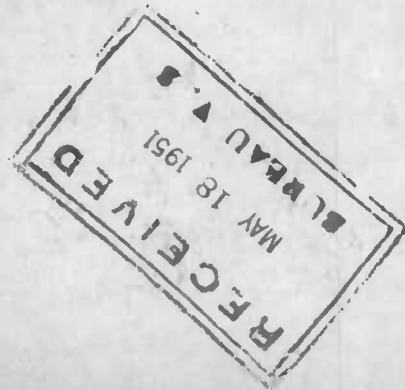
ADDRESS

5-16-51John Mace, Jr., M.D.Anna A. Burtage Berlin Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04820

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>		STREET ADDRESS (If rural, give location) <u>--</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ida</u> (Middle) <u>--</u> (Last) <u>Guienot</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>5-27-1886</u>
9. AGE last birthday <u>64</u> yrs.		10. If under 1 year Months <u>--</u> Days <u>--</u> Hours <u>--</u> Min. <u>--</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Harrie Bory</u>		14. MOTHER'S MAIDEN NAME <u>Ida (?)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT AND ADDRESS <u>Eastern Shore State Hospital records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Cerebral Hemorrhage

5 hrs.

Antecedent cause(s)

(b) General Arteriosclerosis

Several yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Involuntional Psychosis (Melancholia)

1938

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-18, 1948, to 5-24, 1951, that I last saw the deceasedalive on 5-24, 1951, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/25/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Eastern Shore State Hosp.</u>	LOCATION (City, town, or county) <u>Cambridge, Maryland</u>	(State) <u>--</u>
DATE REC'D BY LOCAL REG. <u>May 28, 1951</u>	REGISTRAR'S SIGNATURE <u>John Mace, Jr., M.D.</u>	24. FUNERAL DIRECTOR <u>LeCompte Funeral Service,</u> <u>Cambridge, Maryland</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A151

RECEIVED
MAY 29 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 115

04821

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>		STREET ADDRESS (If rural, give location) <u>unknown</u>	
3. NAME OF DECEASED (First) <u>Lulu</u> (Middle) <u>-</u> (Last) <u>Hickman</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>f</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>separated</u>	8. DATE OF BIRTH <u>Jan. 16-1886</u>
9. AGE last birthday <u>65</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Accomac County, Virginia</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Collins</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Outen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Henry Walters, Attorney and Trustee</u>		18. MEDICAL CERTIFICATION <u>Pocomoke City, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Primary Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

5 days

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Epilepsy w/o Psychosis

1919

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Epilepsy w/o Psychosis

1919

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from December 15, 1949, to May 10, 1951, that I last saw the deceased

alive on MAY 9, 1951, and that death occurred at 2:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL SPECIES		DATE THEREOF <u>May 12-51</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cemetery, Scorgetown, Md.</u>		LOCATION (City, town or county) (State)	
DATE REC'D BY LOCAL REG. <u>May 11, 1951</u>		REGISTRAR'S SIGNATURE <u>John Mace, Jr., M.D.</u>		24. FUNERAL DIRECTOR <u>Ronald James Williams</u>		ADDRESS <u>Eastern Shore State Hospital, Cambridge.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04822

Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>85 Washington Street</u>		STREET ADDRESS (If rural, give location) <u>85 Washington Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>NATHANIEL HUGHES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 31, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11-14-1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - shoe shoes</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday (If under 1 year Months Days) (If under 24 hrs Hours Min.) <u>44 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Woolford</u>		14. MOTHER'S MAIDEN NAME <u>Lily Mae Hughes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Lillian Ward, sister</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

30 Min.

420.1 Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

94a II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

6-1-1951 DATE SIGNED

John Mace, Jr., M.D., Deputy Medical Examiner, Cambridge, Maryland

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
Burial 6-2-1951 Bethel Cemetery Cambridge, Maryland

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS
Lewis H. Bayneum, Cambridge, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

751848

RECEIVED
JUN 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04823

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge-Maryland Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elliotts Island</u> STREET ADDRESS <u>(None)</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM F. HUGHES</u>		4. DATE OF DEATH <u>MAY 1 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8/14/1876</u>
9. AGE last birthday <u>74</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing Industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Ecciminy Hughes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>310 West End Ave. Kenneth S. Hughes-Cambridge, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage, R+.

INTERVAL BETWEEN ONSET AND DEATH

2 hours

Antecedent cause(s)

(b)

Hypertension

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5/1, 1951, to 5/1, 1951, that I last saw the deceasedalive on 5/1, 1951, and that death occurred at 2:05 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/3/1951</u>	<u>Elliotts Methodist Churchyard-</u>	<u>Elliotts, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 8, 1951</u>	<u>John Mace, Jr., M.D.</u>	<u>LeCompte Funeral Service,</u>		

Cambridge, Maryland 7/10/26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04824

Reg. Dist. No. 11.6

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> TOWN <u>Cambridge</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>In ambulance on Washington St.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> TOWN <u>Cambridge</u> STREET ADDRESS (If rural, give location) <u>6 Skinner's Court</u>			
3. NAME OF DECEASED (Type or Print) <u>Edward</u> (First) <u>(not known)</u> (Middle) <u>Jones</u> (Last)		4. DATE OF DEATH <u>May</u> <u>3</u> <u>1951</u> (Month) (Day) (Year)		5. SEX <u>male</u>		6. COLOR OR RACE <u>negro</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		8. DATE OF BIRTH <u>? 1889</u>		9. AGE last birthday <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>oyster shucker</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Annie Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>unknown</u>		17. INFORMANT <u>Ollie Jackson, Cambridge, Maryland</u>		18. MEDICAL CERTIFICATION (SISTER)	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Occlusion</u>						<u>5 minutes</u>	
Antecedent cause(s) (b) <u>Arterio-sclerosis generalized</u>						<u>?</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>-- --</u>							
19a. DATE OF OPERATION <u>--</u>				19b. MAJOR FINDINGS OF OPERATION <u>--</u>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>--</u>				PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>--</u>			
TIME (Month) (Day) (Year) (Hour) <u>--</u>				INJURY OCCURRED <u>--</u>			
OF INJURY <u>--</u>				HOW DID INJURY OCCUR? <u>--</u>			
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <u>Eldridge H. Wolf</u> Assistant Deputy Medical Examiner <u>Cambridge, Maryland</u>						DATE SIGNED <u>5-7-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-7-1951</u>		NAME OF CEMETERY OR CREMATORY <u>Silent City Cemetery</u>		LOCATION (City, town, or county) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>May 8, 1951</u>		REGISTRAR'S SIGNATURE <u>John Mace, Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>Lewis H. Bayneum, Cambridge, Maryland</u>		ADDRESS <u>--</u>	

690126

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAY 10 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04825

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE New Jersey COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cambridge		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Morristown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge-Maryland Hosp.		STREET ADDRESS (If rural, give location) 150 Mt. Kemble Avenue ✓	
3. NAME OF DECEASED (Type or Print) JOSEPHINE C. LOONEY		4. DATE OF DEATH (Month) MAY (Day) 2 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORGED (Specify) Married	8. DATE OF BIRTH 12/22/1896
9. AGE last birthday 54 yrs.		10. If under 1 year: Months 0 Days 0 Hours 0 Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Luby		14. MOTHER'S MAIDEN NAME Margaret O'Neal	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS Charles J. Looney-Morristown N.J.		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) **Coronary occlusion**Antecedent cause(s) (b) **12 hours**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **5/1**, 19**51**, to **5/2**, 19**51**, that I last saw the deceased alive on **5/2**, 19**51**, and that death occurred at **10:20 A**.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 5/5/51		NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		LOCATION (City, town, or county) (State) Hanover, New Jersey	
DATE REC'D BY LOCAL REG. May 5, 1951		REGISTRAR'S SIGNATURE John Mace, Jr. M.D.		24. FUNERAL DIRECTOR LeCompte Funeral Service,		ADDRESS Cambridge, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-T

RECEIVED
MAY 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04826

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <i>Fordester</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Somerset</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Laurelbridge Md</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Crisfield</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Eastern Shore State Hospital</i>		STREET ADDRESS (If rural, give location) <i>7th and Main Street</i>	
3. NAME OF DECEASED (Type or Print) <i>Charles T. Maddix</i>		4. DATE OF DEATH (Month) <i>May</i> (Day) <i>28</i> (Year) <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept. 8 - 1876</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retirement</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>74</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Crisfield, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Maddix</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT AND ADDRESS <i>Mrs Franklin Smeade 7th and Main Street Crisfield Md.</i>		18. MEDICAL CERTIFICATION <i>(Slaughter)</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Cardiac failure.</i>			<i>Several hours</i>
Antecedent cause(s) (b) <i>General arteriosclerosis - Cardiac enlargement - Partial heart block</i>			<i>Several years</i>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Subtrochanteric fracture left femur - due to weakness</i>			<i>one week</i>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Psychosis due to cerebral Arteriosclerosis</i>			<i>(6-8-51 - ams)</i>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <i>HOMICIDE</i>		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>10:00 p.m.</i> , 19 <i>50</i> , to <i>May 28</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>May 28</i> , 19 <i>57</i> , and that death occurred at <i>9:15 p.m.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Alfred L. Ledermann M.D.</i>		ADDRESS <i>Eastern Shore State Hosp. Laurelbridge, Md</i> DATE SIGNED <i>May 28/57</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>May 29, 1957</i>	
NAME OF CEMETERY OR CREMATORY <i>Crisfield Cemetery</i>		LOCATION (City, town, or county) (State) <i>Crisfield, Maryland</i>	
DATE REC'D BY LOCAL REG. <i>May 29, 1957</i>		REGISTRAR'S SIGNATURE <i>John Mace, Jr. M.D.</i>	
24. FUNERAL DIRECTOR <i>Bradshaw Funeral Parlors</i>		ADDRESS <i>Crisfield, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 31 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11.6

04827

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>413 Maryland Avenue</u>		STREET ADDRESS (If rural, give location) <u>413 Maryland Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LOTTIE</u>	(Middle) <u>HAYWARD</u>	(Last) <u>MERRICK</u>
4. DATE OF DEATH	(Month) <u>MAY</u>	(Day) <u>10</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8/9/1889</u>
9. AGE last birthday <u>61 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph K. Hayward</u>		14. MOTHER'S MAIDEN NAME <u>Mary T. Kimmey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>215-03-6426</u>	
17. INFORMANT AND ADDRESS <u>Fannie Peregoy- Baltimore, Maryland</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of the rectum with metastases

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.19a. DATE OF OPERATION November 1949 at Johns Hopkins Hospital.

19b. MAJOR FINDINGS OF OPERATION

Unknown.

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from March, 1951, to May 10, 1951, that I last saw the deceased alive on May 9, 1951, and that death occurred at 11:40 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/13/1951</u>	<u>Cambridge Cemetery</u>	<u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>May 15, 1951</u>	<u>John Mace, Jr., M.D.</u>	<u>LeCompte Funeral Service</u> <u>Cambridge, Maryland</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 17 1961
BUREAU A. D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04828

CERTIFICATE OF DEATH

Reg. Dist. No. 111

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>East New Market Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>East New Market Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Henrietta Leist</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>27</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7/4/1858</u>
9. AGE last birthday <u>92</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Leist</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Schmidt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Bertha Pearson Daughter</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute Cardiac Dilatation

INTERVAL BETWEEN ONSET AND DEATH

1 day

Antecedent cause(s)

(b) Pericarditis Aqueous

10 yrs

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) unknown

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Scrubby - valvular

6 yrs

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While st Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 5, 1957, to 5-27, 1957, that I last saw the deceased

alive on 5-26, 1957, and that death occurred at 4 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

JUL 17 1961

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

04829

1. PLACE OF DEATH COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u> TOWN <u>Cambridge</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wor.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> TOWN <u>Snow Hill</u> STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print) <u>RICHARD</u> (First) <u>A.</u> (Middle) <u>MORGAN</u> (Last)		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>1869</u>
9. AGE last birthday <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sign painter</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard Reese Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Louise Collier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Eastern Shore State Hospital records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>1 hour</u>
Antecedent cause(s) (b) <u>General Arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Psychosis with Psychopathic Personality</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/8/51, 1950, to May 14, 1951, that I last saw the deceased alive on May 11, 1951, and that death occurred at 7:10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>	DATE THEREOF <u>5-17-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Eastern Shore State Hospital</u>	LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>
DATE REC'D BY LOCAL REG. <u>May 19, 1951</u>	REGISTRAR'S SIGNATURE <u>John Mace, Jr., M.D.</u>	24. FUNERAL DIRECTOR <u>Kenneth L. Thomas</u>	ADDRESS <u>Cambridge</u>

564808

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
MAY 21 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04830

Reg. Dist. No. 11

1. PLACE OF DEATH COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN East New Market		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN East New Market	
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.		STREET ADDRESS R.F.D. (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
LENA	MC NAMARA	PHILLIPS	
4. DATE OF DEATH	(Month)	(Day)	(Year)
MAY	18	1951	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	White	Married	11/4/1890
9. AGE last birthday	If under 1 year	If under 24 hrs	
60 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	U.S.A.
13. FATHER'S NAME William McNamara		14. MOTHER'S MAIDEN NAME Not known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
no		none	
17. INFORMANT AND ADDRESS		East New Market, Mr. Thomas Phillips: Maryland	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Gun shot wound of brain.	Instant
Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	
(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY Home
(CITY OR TOWN) East New Market	(COUNTY) Dor. (STATE) Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY May 18 51 11a	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
HOW DID INJURY OCCUR? Shot self with 32 pistol.	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE **John M. D.** (Degree or title) ADDRESS **Cambridge, Md.** DATE SIGNED **5/21/51**

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	5/21/1951	East New Market Cemetery-	East New Market,	Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
May 21, 1951	John M. D.	LeCompte Funeral Service, Cambridge, Maryland		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1951

BUREAU F. B. I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

04831

1. PLACE OF DEATH-COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED-STATE <i>Maryland</i> COUNTY <i>Dor.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>422 Race Street</i>		STREET ADDRESS (If rural, give location) <i>422 Race St.</i>	
3. NAME OF DECEASED (Type or Print) <i>Nona</i> (First) <i>Inslay</i> (Middle) <i>Pritchett</i> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <i>May 25 1951</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>April 18, 1876</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>79</i> yrs.
13. FATHER'S NAME <i>Levin Inslay</i>		11. BIRTHPLACE (State or foreign country) <i>Dorchester Co.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT AND ADDRESS <i>Mrs. S. James Tyler Cambridge</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <i>Coronary Thrombosis</i>		<i>1/2 hr.</i>
Antecedent cause(s) (b) <i>Hypertension and Cardiac Vascular Disease</i>		<i>4 yrs.</i>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Arteriosclerosis of spine</i>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, or office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *5-5*, 19*47*, to *5-25*, 19*51*, that I last saw the deceased alive on *5-19*, 19*51*, and that death occurred at *8:30 A.M.*, from the causes and on the date stated above.

SIGNATURE *Arthur Bunker M.D.* ADDRESS *Cambridge Maryland 576-51* DATE SIGNED *5-26-51*

23. BURIAL, CREMATION, RE-INTERMENT (Specify)	DATE THEREOF	NAME OF CEMETERY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>5-27-51</i>	<i>Greenlawn</i>	<i>Cambridge, Md.</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>May 29, 1951</i>	<i>John Mace, Jr. M.D.</i>	<i>Kenneth R. Thomas</i>	<i>Cambridge Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 31 1951
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04832

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Cambridge</u> TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS (Cambridge Harbor)		STREET ADDRESS (If rural, give location) <u>Race Street Extd.</u>	
3. NAME OF DECEASED (Type or Print) <u>EDGAR</u> (First) <u>C.</u> (Middle) <u>RUARK</u> (Last)		4. DATE OF DEATH <u>MAY</u> <u>19</u> <u>1951</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>3/17/1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food Industry</u>	9. AGE last birthday <u>42</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus C. Ruark</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Ruark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY No. <u>215-26-5479</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Emory Collins: Cambridge, Md.</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Accidental drowning</u>		<u>5 min.</u>
Antecedent cause(s) (b) <u>85% 172 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Injury Harbor</u>	(CITY OR TOWN) <u>Cambridge</u> (COUNTY) <u>Dor.</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 19 51 4p.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell from boat.</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE <u>[Signature]</u> M.D. (Degree or title)		DATE SIGNED <u>5/21/51</u>
Deputy Medical Examiner <u>Cambridge, Md.</u>		
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>5/22/1951</u>	<u>Methodist Churchyard</u>
LOCATION (City, town, or county) (State)		
<u>Taylor's Island, Md.</u>		
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
<u>May 21, 1951</u>	<u>John Mac, Jr., M.D.</u>	<u>LeCompte Funeral Service,</u>
<u>Cambridge, Maryland 9/10/26</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04833

CERTIFICATE OF DEATH

Reg. Dist. No. 11.6

1. PLACE OF DEATH- COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Dor.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Cambridge, Md. Hosp</i>		STREET ADDRESS (If rural, give location) <i>12 Cross Street</i>	
3. NAME OF DECEASED (Type or Print) <i>Frank</i> (First) <i>B.</i> (Middle) <i>Saunders</i> (Last)		4. DATE OF DEATH (Month) <i>May</i> (Day) <i>26</i> (Year) <i>1951</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Dec 25 1889</i>
9. AGE last birthday <i>61</i> yrs. <i>3</i> Months <i>1</i> Days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor</i>	
11. BIRTHPLACE (State or foreign country) <i>Dorchester Co. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>William Saunders</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Pinkett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>212-14-4209</i>	
17. INFORMANT AND ADDRESS <i>George Saunders, Cambridge, Md</i>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Acute intestinal obstruction

Antecedent cause(s)

(b)

*570.5 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last**122b*

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *5-25-51*, 19*51*, to *5-26-51*, 19*51*, that I last saw the deceasedalive on *5-25-51*, 19*51*, and that death occurred at *9:45 A.M.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*May 31, 1951**John Mace, Jr. M.D.**Herbert M. St. Clair, Jr. Cambridge, Md*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

770 808

BUREAU V. 1

JUN 4 1951

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11.6

04834

Deceased's name - Benjamin Lee Robinson Stanley

1. PLACE OF DEATH - COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2 Day Hospital</u>		STREET ADDRESS (If rural, give location) <u>8 Phillips St.</u>	
3. NAME OF DECEASED (Type or Print) <u>infant</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>6</u> (Year) <u>1951</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>May 4, 1951</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	9b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>1</u> yrs. <u>6</u> mos. <u>4</u> days	10. CITIZEN OF WHAT COUNTRY? <u>USA</u>
11. FATHER'S NAME <u>William Robinson</u>	12. MOTHER'S MAIDEN NAME <u>Rebecca May Stanley</u>		
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	14. SOCIAL SECURITY NO. <u>-</u>	15. INFORMANT AND ADDRESS <u>William Robinson</u>	
16. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
(a) Immediate cause <u>Prematurity - Cerebral hemorrhage</u>			
(b) Antecedent cause(s) <u>760.5 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c) 160a			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
17a. DATE OF OPERATION	17b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/4</u> , 19 <u>51</u> , to <u>5/6</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5/6</u> , 19 <u>51</u> , and that death occurred at <u>7:00</u> a.m., from the causes and on the date stated above.			
SIGNATURE <u>Lawrence Mangan</u>		DATE SIGNED <u>5/8/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-7-51</u>	NAME OF CEMETERY OR CREMATORY <u>Silent City Cemetery, Cambridge, Md.</u>	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <u>May 8, 1951</u>	REGISTRAR'S SIGNATURE <u>Joan Mace, Jr., M.D.</u>	24. FUNERAL DIRECTOR <u>Lewis J. Bayne</u>	ADDRESS <u>Cambridge, Maryland</u>

405041195200

RECEIVED

MAY 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04835

Reg. Dist. No. 115

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bishops Head</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge-Maryland Hosp.</u>		STREET ADDRESS (If rural, give location) <u>(none)</u>	
3. NAME OF DECEASED (Type or Print) <u>IDA</u> (First) <u>BRAMBLE</u> (Middle) <u>TODD</u> (Last)		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8/24/1885</u>
9. AGE last birthday <u>65</u> Months <u>1</u> year <u>4</u> days <u>19</u> hrs. <u>51</u> min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Bishops Head, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Bramble</u>	
14. MOTHER'S MAIDEN NAME <u>Minnie Daytone</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Brayde P. Todd- Bishops Head, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>Broncho-pneumonia</u>			<u>5 days</u>
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Cerebral hemorrhage</u>			<u>25 days</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-22-1951</u> , to <u>5-4-1951</u> , that I last saw the deceased alive on <u>5-4-1951</u> , and that death occurred at <u>1:02 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Albert Bunker</u>		ADDRESS <u>9 Lane St., Cambridge-Md.</u>	
DATE SIGNED <u>5-4-51</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/6/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Bethany Church</u>		LOCATION (City, town, or county) (State) <u>Crocheron, Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 7, 1951</u>		REGISTRAR'S SIGNATURE <u>John Mac. Jr. M.D.</u>	
FUNERAL DIRECTOR <u>LeCompte Funeral Service.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 9 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04836

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH - COUNTY <u>Dorchester</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Burlock</u>		LENGTH OF STAY (in this place) <u>13 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Burlock, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>Main Street</u>	
3. NAME OF DECEASED (Type or Print)		(First) <u>Allen</u> (Middle) <u>Elsworth</u> (Last) <u>Troup</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>24</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8/8/1872</u>	9. AGE last birthday <u>78</u> yrs.	10. <u>Under 1 year</u> Months <u>5</u> Days <u>24</u> Hours <u>1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator, Inc.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>John Vananaku</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Blendy Harrison Troup</u>		14. MOTHER'S MAIDEN NAME <u>Leah Shearer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>123-45-6789</u>		17. INFORMANT AND ADDRESS <u>Mrs. William T. Smith Daughter</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Occlusion</u>				<u>1 hour</u>	
Antecedent cause(s) (b) <u>Chronic Myocarditis</u>				<u>5 yrs +</u>	
(c) <u>Auricular Fibrillation - Chronic</u>				<u>5 yrs +</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 23, 1951</u> , to <u>May 23, 1951</u> , that I last saw the deceased alive on <u>May 23, 1951</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>W.C. Harrison MD</u>		(Degree or title)		ADDRESS <u>Burlock, Md.</u> DATE SIGNED <u>5/24/57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/26/1957</u>		NAME OF CEMETERY OR CREMATORY <u>Shoemakersville</u> LOCATION (City, town, or county) <u>Shoemakersville</u> (State) <u>Pa.</u>	
DATE REC'D BY LOCAL REG. <u>5/24/57</u>		REGISTRAR'S SIGNATURE <u>Chas W Hastings</u>		24. FUNERAL DIRECTOR <u>W. B. Willoughby</u> ADDRESS <u>314 802 MD</u>	

MARGIN RESERVED FOR BINDING

VS. A15-1

RECEIVED
MAY 31 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04837

CERTIFICATE OF DEATH

Reg. Dist. No. 11.6

1. PLACE OF DEATH COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and give nearest town) Cambridge		CITY (If outside corporate limits, write RURAL and give nearest town) Snow Hill	
TOWN Cambridge		TOWN Snow Hill	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge-Maryland Hosp.		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Walter C. Turner		4. DATE OF DEATH (Month) May (Day) 29 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 6 - 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired hardware merchant		10b. KIND OF BUSINESS OR INDUSTRY own store	9. AGE last birthday 79 yrs. 3/23
11. BIRTH PLACE (State or foreign country) Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joshua W. Turner		14. MOTHER'S MATHEN NAME Sarah Hawkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY No. None	
17. INFORMANT B.W. Turner 1306 Division St. Salisbury, Md.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial failure		2 days
Antecedent cause(s)	(b) Hypertensive Cardiovascular disease		?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Partial intestinal obstruction		2 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (cause unknown)			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **5/27/51** 19....., to **5/29/.....**, 19.. **51** that I last saw the deceased alive on **5/28/51**, 19....., and that death occurred at **3.....** m., from the causes and on the date stated above.

SIGNATURE **John Mace Jr.** (Degree or title) **M.D.** ADDRESS **Cambridge, Md.** DATE SIGNED **5/29/51**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE May 31/51	NAME OF CEMETERY OR CREMATORY Whatecoat Methodist	LOCATION (City, town, or county) Snow Hill, Md
DATE REC'D BY LOCAL REG. May 31, 1951	REGISTRAR'S SIGNATURE John Mace, Jr., M.D.	24. FUNERAL DIRECTOR May E. Dennis	ADDRESS Snow Hill, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1951
BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04838

Reg. Dist. No. 116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> LENGTH OF STAY (in this place) <u>entire life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>311 Maryland Ave.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dor.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> STREET ADDRESS (If rural, give location) <u>311 Maryland Ave.</u>			
3. NAME OF DECEASED (First) <u>Sallie</u> (Middle) <u>Wright</u> (Last) <u>Twilley</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>6</u> (Year) <u>1951</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June, 29, 1871</u>	9. AGE last birthday <u>79</u> yrs. If under 1 year Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u>			
13. FATHER'S NAME <u>William Wright</u>		14. MOTHER'S MAIDEN NAME <u>Annie Wherrette</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs. Sarah Shepherd, Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH		
(a) <u>Cerebral Hemorrhage Rt.</u>					<u>10 days</u>		
(b) <u>Arteriosclerosis</u>							
(c) <u>Cerebral Hemorrhage with aphasia</u>					<u>10 years</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					<u>ago</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/28</u> , 1951, to <u>5/6</u> , 1951, that I last saw the deceased alive on <u>5/6</u> , 1951, and that death occurred at <u>11:30 a.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>Cambridge, Md.</u> DATE SIGNED <u>5/7/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-8-51</u>		NAME OF CEMETERY OR CREMATORY <u>Cambridge</u> LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>			
DATE REC'D BY LOCAL REG. <u>May 11, 1951</u>		REGISTRAR'S SIGNATURE <u>John Mace, Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>Kenneth R. Thomas</u> ADDRESS <u>Kenneth R. Thomas, Cambridge, Md.</u>			

M

** W W **

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04839

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>416 High Street</u>		STREET ADDRESS (If rural, give location) <u>416 High Street</u>	
3. NAME OF DECEASED (First) <u>Mitchell</u> (Middle) <u>James</u> (Last) <u>Wongus</u>		4. DATE (Month) (Day) (Year) <u>May 31 1951</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 28 1886</u>	
9. AGE last birthday <u>65 yrs.</u>		10. BIRTHPLACE (State or foreign country) <u>Salem DorCo Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Salem DorCo Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mitchell Wongus</u>		14. MOTHER'S MAIDEN NAME <u>Jane Hopkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>24-07-8197</u>	
17. INFORMANT AND ADDRESS <u>Hattie Wongus, Cambridge, Md.</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute Cardiac Failure</u>	<u>40 mins</u>
Antecedent cause(s) (b) <u>Hypertensive Cardio-Vascular Heart Disease</u>	<u>4 yrs. approx.</u>
(c) <u>443X 93d</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5/31 1951</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5/31 1951, to 5-31 1951, that I last saw the deceased alive on 5-31 1951, and that death occurred at 3:45 A.M. from the causes and on the date stated above.

SIGNATURE Harold S. Wilson, M.D. ADDRESS 224 Pine St. Camb. Maryland DATE SIGNED June 3, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 3, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Salem</u>	LOCATION (City, town, or county) <u>Salem, DorCo Md</u>
DATE REC'D BY LOCAL REG. <u>June 2, 1951</u>	REGISTRAR'S SIGNATURE <u>John M. St. Clair, Jr.</u>	24. FUNERAL DIRECTOR <u>Herbert M. St. Clair, Jr.</u>	ADDRESS <u>Cambridge</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1951
BUREAU W. S.